DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 12 1940
399

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9529

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 963

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town K.C. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Menorah Hosp (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days) In this community Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 5909 East 18th (If rural, give location)
(e) If foreign born, how long in U. S. A.? Life years.

3. (a) PRINT FULL NAME William Jordan 63
3. (b) If veteran, name war — 3. (c) Social Security No. —

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced —
6. (b) Name of husband or wife Child | 6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Feb (Month) -27- (Day) 1940 (Year)

8. AGE: Years | Months | Days | If less than one day 48 hr. — min.

9. Birthplace K.C. (City, town, or county) Mo (State or foreign country)
10. Usual occupation Child
11. Industry or business —
MOTHER FATHER
12. Name John Jordan
13. Birthplace Holland (City, town, or county) (State or foreign country)
14. Maiden name Bertha Bergdoll
15. Birthplace Neb (City, town, or county) (State or foreign country)
16. (a) Informant's own signature John Jordan
(b) Address 5907 East 18th
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof — (Month) (Day) (Year)
(c) Place: burial or cremation Queen Lawn
18. (a) Signature of funeral director Rose E Gordon
(b) Address K.C. Mo
19. (a) Mch 1, 1940 (Date received local registrar) (b) H. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 29
year 1940 hour 2 minute 30 A.M.
21. I hereby certify that I attended the deceased from — to —, 19—;
that I last saw h— alive on —, 19—;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Congenital atresia of Common bile duct	
Due to —	15 D
Due to —	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations —	
Of autopsy Autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work (e) Means of injury —
23. Signature — (M.D. or other)
Address — Date signed 3/1/40

(Licensed Embalmer's Statement on Reverse Side)

50M-6-17-39
Rev. 8-17-39
(Form 1 X19511)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Van Lawson - (Apprentice), Registered Apprentice No.....,

working under my personal supervision.

Signed John B. Clark Jr.

Licensed Embalmer No. 2965

P. O. Address W. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.